Emergency Preparedness Mass Immunization Consent 2008-2009

I hereby authorize the physicians, nurses, and/or nurse practitioners of the Virginia Department of Health to immunize me against influenza. I have received a Vaccine Information Statement about the influenza. I understand the risks and benefits of the vaccine and have had the opportunity to ask questions. I agree that this immunization record may be shared with other health care providers. I understand that this information will be used by health care providers for the care of my self or for statistical purposes only. I understand that this information will be kept confidential. Information about the Deemed Consent for blood borne diseases has been made available to me and I understand it. I understand that medical records are kept for 5 years after death, 10 years after my last visit..

Print Name of Person to Receive Vaccine

Last _____ First _____ MI _____ Sex: M F

Birth date (Month-Date-Year) _____ Race _____ Marital Status: S M D W Sep

Street Address _____ Apt. _____

City _____ State _____ Zip _____ Telephone # _____

Social Security Number_____-_____-_____

Signature **XX**_____ Date _____

Are you sick today? **Yes No**
Have you had a flu shot before? **Yes No**
Do you have any allergies to eggs, latex, thimerosol, medication, any vaccine, or other vaccine component? **Yes No** **If yes, please list allergies:** _____

Have you ever had Guillain-Barre syndrone? Yes No

What is Deemed Consent? As a health care provider, we are required by Sec. 32.1-45-1 of the Code of Virginia (1950), as amended, to give you the following notice, which would pertain to you or your child.

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus ("HIV", the "AIDS" virus) and for the presence of the hepatitis B and hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus ("HIV", the "AIDS" virus) and the presence of hepatitis B and hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

For Office Use Only
Vaccine: Influenza VIS 7/24/08
Lot no. _____
Site _____
Nurse Signature_____ Print Name_____